STATE OF WASHINGTON
DEPARTMENT OF LABOR AND INDUSTRIES
PO Box 44261 Olympia, Washington 985044261

BILLING INSTRUCTIONS - STATE FUND CLAIMS

HOME CARE

The Washington State Department of Labor and Industries State Fund, or Self-Insured employer is responsible for the costs of medically necessary services associated with an accepted industrial injury. No co-payments or deductibles are required or allowed from workers or other payers. Home care/home health services require prior authorization, which can be obtained through the injured workers claims manager or the ONC's who review the medical necessity. Rules for reimbursement and billing of home nursing and attendant care are explained in the department's Medical Aid Rules and Fee Schedules. The Washington Administrative Codes (WACs) relating specifically to home care are:

WAC 296-20-01002,WAC 296-20-091 & WAC 296-20-303

Please see current Provider Bulletin on Attendant Services. To obtain a current copy of the Provider Bulletin, please call (360) 902-6799.

Table of Contents

DIRECTORY: FIELD SERVICE OFFICES

Aberdeen:
415 West Wishkah, Suite 1B
Aberdeen WA 98520-0013
(360) 533-8200

Bellevue:
616 120th Avenue NE, Suite C201
Bellevue WA 98005-3037
(425) 990-1400

Bellingham:
1720 Ellis Street, Suite 200
Bellingham WA 98225-4600
(360) 647-7300

Bremerton:
500 Pacific Avenue, Suite 400
Bremerton WA 98337-1904
(360) 415-4000

Colville:
298 South Main, Suite 203
Colville WA 99114-2416
(509) 684-7417
1-800-509-9174

East Wenatchee:
519 Grant Road
East Wenatchee WA 98802-5459
(509) 886-6500
1-800-292-5920

Everett:
729 100th St SE
Everett WA 98208-3727
(425) 290-1300

Kennewick:
4310 W 24th Ave
Kennewick WA 99338-1992
(509) 735-0100
1-800-547-9411

Longview:
900 Ocean Beach Hwy
Longview WA 98632-4013
(360) 575-6900

Moses Lake:
3001 W Broadway Ave
Moses Lake WA 98837-2907
(509) 764-6900

Mount Vernon:
525 E College Way, Suite H
Mount Vernon WA 98273-5500
(360) 416-3000

Okanogan:
1234 2nd Avenue S
Okanogan WA 98840-0632
(509) 826-7345

Port Angeles:
1605 East Front Street, Suite C
Port Angeles WA 98362-4628
(360) 417-2700

Pullman:
1250 Bishop Blvd SE, Suite G
PO Box 847
Pullman WA 99163-0847
(509) 334-5296
1-800-509-0025

Seattle:
300 W Harrison Street
Seattle WA 98119-4081
(206) 281-5400

Spokane:
901 N Monroe Street, Suite 100
Spokane WA 99201-2149
(509) 324-2600
1-800-509-8847

Tacoma:
950 Broadway Suite 200
Tacoma WA 98402-4453
(253) 596-3800

Tukwila:
12806 Gateway Drive
PO Box 69050
Seattle WA 98168-1050
(206) 248-8240

Tumwater:
PO Box 44851
7273 Linderson Way SW
Olympia WA 98504-4851
(360) 902-5799

Vancouver:
312 SE Stonemill Dr, Suite 120
Vancouver WA 98684-3508
(360) 896-2300

Walla Walla:
1815 Portland Avenue, Suite 2
Walla Walla WA 99362-2246
(509) 527-4437

Yakima:
15 W Yakima Avenue, Suite 100
Yakima WA 98902-3480
(509) 454-3700
1-800-354-5423

BILLING INSTRUCTIONS

We process all bills using an automated system called the Medical Information and Payment System (MIPS). In order to process your billings promptly and accurately, they must be completed as described. Improperly submitted bills will be denied or returned for completion or correction.

Any changes to a previously submitted bill must be made on the Department's "Provider's Request for Adjustment" form, using the original Internal Control Number (ICN).

Who bills on what form?

Spouses, friends, relatives who are self-employed attendants (non-professional or non-agency based): Submit charges for home care on the department's specific 'blue' Statement for Home Nursing Services form (F248-160-000).

Home care agencies, home health service agencies, skilled nursing facilities and institutions: Submit charges for home care on the department's specific 'green' Statement for Miscellaneous Services form (F245-072-000).

Where to mail bill?

Mail both Home Nursing Services & Miscellaneous Services bills to:

Department of Labor and Industries
PO Box 44267
Olympia WA 98504-4267

Bills may be submitted on paper forms or electronically.

Please contact the Electronic Billing Unit at (360) 902-6511 or (360) 902-6512 to submit bills electronically.

Bills must be received within one year from the date of service. We cannot process bills submitted 12 months or longer after the service. An exception is considered when litigation or other worker related question of coverage is the reason for late billing. In this circumstance, supporting documentation must be submitted with a copy of the original bill and a Provider's Request for Adjustment form.

For help:

If you have questions related to bills, please call the Provider Hotline at 1-800-848-0811.

If you have questions related to the status of a claim or time-loss payment, please call the Claims Information line at 1-800-831-5227.

COMPLETING THE "STATEMENT FOR MISCELLANEOUS SERVICES" and the "STATEMENT FOR HOME NURSING SERVICES" FORMS

Note: Do not write, print or staple any attachments in the bar code area at the top of the form.

Attachments:
Attach a copy of the doctor's signed prescription and manufacturer's itemized cost invoices. Receipts are required for all claimant reimbursements. Enter the injured worker's name and claim number in the upper right corner of each page

FIELD DESCRIPTION / INSTRUCTIONS FOR COMPLETING

1 If applicable, check the box titled "Home Health/Nursing Home Services" on the Statement for Miscellaneous Services bill form.

2 **WORKER'S NAME in full:** Enter injured worker's last name, first name and middle initial.

3 **SOCIAL SECURITY NUMBER:** Enter injured worker's social security number. This information helps identify the proper claim when the claim number has been entered incorrectly or the worker's name is common.

4 **CLAIM NUMBER:** Enter injured worker's claim number. Claim numbers are alpha-numeric, consisting of seven characters. The letter identifies the funding source.

STATE FUND INDUSTRIAL INSURANCE

All State Fund claim numbers are six digits, preceded by one, of the following letters: B, C, F, G, H, J, K, L, M, N, P, X or Y. Send bills for State Fund claims to:

Department of Labor and Industries
PO Box 44267
Olympia WA 98504-4267

CRIME VICTIM COMPENSATION PROGRAM

Crime victim claim numbers are either six digits preceded by a "V", or five digits preceded by a VA, VB, VC, VH or VJ. Send all bills for Crime Victims claims to:

Crime Victim Compensation Program
Department of Labor and Industries
PO Box 44520
Olympia WA 98504-4520

SELF-INSURANCE

Self-Insurance claim numbers are six digits preceded by an S, T or W. Self-Insurance claims should be sent directly to the employer or their service company. Department bill forms, Self-Insured forms, or other forms acceptable to the Self-Insurer may be used. If you have any questions about Self-Insured billing, please call the worker's employer or Labor and Industries' Self-Insurance section at (360) 902-6901.

5 **ADDRESS:** Enter injured worker's current address.

6 **EMPLOYER'S NAME:** Enter injured worker's employer name at the time of injury. This information helps identify the proper claim if the claim number has been entered incorrectly.

7 **DATE OF INJURY:** Enter the date of injury. This date positively identifies each claim. It is important and must be included. A worker may have several claims; therefore, it is vital the proper claim be identified and charged for services provided.

8 **NAME OF REFERRING PHYSICIAN OR OTHER SOURCE:** Enter the name of the doctor who referred the injured worker to you.

9 **REFERRING PHYSICIAN PROVIDER NUMBER:** Enter the referring doctor's L&I provider account number.

10 **DIAGNOSIS CODE:** Not applicable.

11 **FOR GLASSES:** Not applicable.

12 **GIVE HOSPITALIZATION DATES:** Not applicable

13 **ITEMIZATION OF SERVICES AND CHARGES:**

A **DATE(s) OF SERVICE:** Enter in month, day and year (MM/DD/YY format) the date(s) the service was provided or item(s) were furnished.

Intermittent dates of service: Enter one date of service per line.

Consecutive dates of service: Enter the beginning date of service in the "from-date-of-service" box and the ending date in the "to-date-of-service" box.

DO NOT OVERLAP DATES OF SERVICE BETWEEN LINE TO LINE OR BILL TO BILL.

B **POS -PLACE OF SERVICE:** Enter the 2-digit place of service code. See list of codes on the reverse side of the billing form.

C **TOS - TYPE OF-SERVICE:** Enter "9".

D **PROC CODE - PROCEDURE CODE:** Enter the procedure code for the service you have provided. Enter only one code per line.

Current		**Change to eff. 7/1/2001**
8901H	Attendant care, non-agency (per hour)	Remains the same
8902H	Nursing Home or Residential Care (group or boarding home)	Remains the same

8904H	Home Health Agency (per hour)	G0156	Service of home health aid in home health setting, each 15 minutes
8905H	Home Hospice Care	S9126	Hospice care, in the home, per diem
8906H	Facility Hospice Care	Remains the same	
8907H	Home Health Agency Visit (RN) (per day)	Remains the same	
8908H	Home Health Agency Phys Thpy per hour (1 hour limit per day)	G0151	Services of physical therapist in home health setting, each 15 minutes
8909H	Home Health Agency Occ Thpy per hour (1 hour limit per day)	G0152	Services of occupational therapist in home health setting, each 15 minutes
8910H	Home Health Agency Speech Thpy per hour (1 hour limit per day)	G0153	Services of speech and language pathologist in home health setting, each 15 minutes
8912H	Home Health Agency Visit (RN) each additional visit (per day)	Remains the same	
8913H	Independent RN evaluation requested by dept. or self-insurer	Remains the same	
8930H	Home Health Agency LPN care (per hour)	S9124	Nursing care, in the home; by LPN, per hour

E **MOD CODE:** Not applicable.

DESCRIPTION OF SERVICES: Briefly describe the item or service (e.g., RN visits)

F **DENTAL:** Not applicable.

G **HOME NURSING:** Enter the time period and rates you are billing.

Number of Hours/Visits/Days:
- Non-Agency Attendant Care - enter hours
- Home Health Agency or Home Care Agency – enter hours or visits
- Nursing Home - enter days

Hours/Visits/Daily Rate:
- Non-Agency Attendant Care - enter hourly rate
- Home Health Agency or Home Care Agency – enter hourly rate or rate per visit
- Nursing Home - enter daily rate

H **GLASSES:** Not applicable.

I **CHARGES:** Enter the total charges for the service provided.

J **UNIT:** Non-Agency Attendant Care - enter number of hours
Home Health Agency or Home Care Agency – enter number of hours or visits
Nursing Homes - enter number of days

14 **PROVIDER'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER:** Enter your name and current address. If your name, address or business status changes,

send written notification immediately to:

Provider Accounts Section
Department of Labor and Industries
PO Box 44261
Olympia WA 98504-4261

15 **PROVIDER NUMBER:** Enter the L&I provider account number issued to you by the Department of Labor and Industries.

If you do not have an L&I provider account number, call Provider Accounts at (360) 902-5140 to request a provider application form.

Submit your bill after you receive your L&I provider account number or attach it to your completed application ***(only this first time)***.

16 **TOTAL CHARGE:** Enter total of all charges listed in lines 1-13. The Department does not accept "balance forward" or "balance due" billings.

17 **YOUR PATIENT'S ACCOUNT NUMBER:** Enter the number you use to identify the injured worker's account. We will include the account number on your remittance advice. We can accept up to 12 characters.

18 **SIGNATURE/DATE:** Signature may be that of the provider or the person completing the bill form. Regardless of who signs the bill, the provider submitting the bill is responsible for its accuracy. If the bill is prepared by computer, the signature field may be left blank. Enter the date the bill is prepared.

19 **REMARKS:** Enter any further information necessary to explain your charges. When using an unlisted code, please explain in this field.

20 **FEDERAL TAX I.D. NUMBER:** Enter either your Employee Identification Number (EIN) or your Social Security Number (SSN), whichever number you used to apply for a provider account with the department.

NO STAPLES IN
BAR CODE AREA

[redacted]

Dept of Labor and Industries
Claims Section
PO Box 44267
Olympia WA 98504-4267

STATEMENT FOR HOME NURSING SERVICES

DO NOT WRITE IN SPACE >

SAMPLE BILL ONLY

WORKER'S NAME IN FULL First Middle	Social Security Number (for ID only)	Claim Number
Last XXXXX XXXXXXXX X	XXX-XX-XXXX	Y 000000
Address: XXXX XXXXXXXXXXX XXX	Employer's Name: ABC EMPLOYER	
City: XXXXXXX State: XX ZIP: XXXXX	Reimburse Injured Worker ☐ Yes ☒ No	Amount Paid $
Date of Injury: XX-XX-XX	Name of referring physician or other source	Referring physician provider number

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
(use ICD-9-CM) Designate left or right when applicable.
1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services
Admitted _____/_____/_____
Discharged _____/_____/_____

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	TOS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing: No of hrs/day	Home Nursing: Hourly Day rate	Glasses: OLD RX OD OS	Glasses: NEW RX OD OS	Charges $	Unit	TO DATE OF SERVICE
7/1/01	XX	9	8901H				5	10.72			1179.20	110	7/31/01

Working 5 hrs a day Monday – Friday
At $10.72 per hour

22 days x 5 hrs = 110 hrs
110 hrs x $10.72 = $1179.20

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: VVVVVVVVVVVVV Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Total Charge
XXXXX XXXXXXXX	$1179.20
Address: XXXX XXXXXXXXXXX XX	Phone Number: (XXX) XXX-XXXX
City: XXXXXXXXX State: XX ZIP + 4: XXXXX	Your Patient's Account Number
Federal tax ID number: XXX-XX-XXXX ☐ EIN ☒ SSN	

NO STAPLES IN BAR CODE AREA

[redacted]

STATEMENT FOR MISCELLANEOUS SERVICES

Dept of Labor and Industries
PO Box 44267
Olympia WA 98504-4267

- ☐ Dental Services
- ☐ Glasses
- ☐ Medical Equipment/ Prosthetics-Orthotics
- ☐ Vocational/ Retraining
- ☐ Transportation
- ☐ Other
- ☒ Home Health/ Nursing Home Services

DO NOT WRITE IN SPACE >

SAMPLE

WORKER'S NAME IN FULL	First	Middle	Social Security Number (for ID only)	Claim Number
Last Doe	John	A	123-45-6789	Y 000000

Address	Employer's Name
114 Foxtail Lane	ABC EMPLOYER

City	State	ZIP	Reimburse Injured Worker	Amount Paid $
Olympia	WA	98512	☐ Yes ☒ No	

Date of Injury	Name of referring physician or other source	Referring physician provider number
XX-XX-XX	XXXXX XXXXXXXXX MD	XXXXXXX

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
(use ICD-9-CM) Designate left or right when applicable.

1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services

Admitted _____/_____/_____

Discharged _____/_____/_____

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	TOS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing		Glasses		Charges $	Unit	TO DATE OF SERVICE
							No of hrs/day	Hourly Day rate	OLD RX OD OS	NEW RX OD OS			
3/1/01	XX	9	XXXXX		XXXXXXXXXX						XX.XX	X	3/1/01

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: Bill date: / /

Remarks:

Provider or Supplier name	Provider number	Total Charge
XXXXX XXX	0000000	$XX.XX

Address	Phone Number
123 E 5th Ave	

City	State	ZIP + 4	Your Patient's Account Number
Any City	WA	00000-0000	XXXXXXXXXX

Federal tax ID number XX-XXXXXXX ☒ EIN ☐ SSN

Referral ID

F245-072-000 statement for misc services 4/01 * Place of Service (POS) and Type of Service (TOS) codes on back

NOTE FOR NON-AGENCY HOME ATTENDANT CARE ONLY

If you are a Non-Agency Home Attendant Care provider **and you do not meet the following exemption status,** see sample remittance page 17. If you meet the following exemption status, see sample remittance page 16.

The department is not obligated to withhold FICA/FUTA if the attendant meets one of the following criteria:

1) the spouse of the person for whom the services are performed;

2) the child of the person for whom the services are provided and is under the age of 21; or

3) the parent of the person for whom services are provided, and the person for whom the services are being provided a) has a child or stepchild living with him or her and the child is either under the age of 18 or has a physical or mental condition which requires the personal care of an adult for at least 4 continuous weeks in a calendar quarter, and b) is divorced, or is a widow or widower, and not remarried, or whose spouse is living at home and has a mental or physical condition which prevents him or her from caring for a child living at home for at least 4 continuous weeks in a calendar quarter.

Non-agency attendant care providers will receive a W-2 form instead of a 1099 Misc form. Those who are in the above categories will not have FICA/FUTA reported on the W-2.

If you begin taking care of an injured worker who is not a spouse, parent or dependent under age 21, you must notify the department by completing another “blue” attendant care application.

SKILLED NURSING FACILITIES

What procedure code should be use for *all* services provided by skilled nursing facilities, transitional care units, and nursing homes?

8902H	Nursing Home, Group Home, Boarding Home services (example: Room/Board, Physical Therapy, Occupational Therapy, Supplies, Laboratory)
19X	The department is not currently accepting this revenue code, you must bill procedure code 8902H on a **HCFA-1500** or **Statement for Miscellaneous Service form #F245-072-000**

What Provider Account Number do I use?

Use your nursing facilities provider account number (provider type 46).

What bill form do I submit my services on?

Skilled Nursing facilities – can either submit charges on the department's specific "green" **Statement for Miscellaneous Services form #F245-072-000 or HCFA-1500.**

REMITTANCE ADVICE DETAIL

The remittance advice provides a detailed report of all bill activity at two-week intervals. If you are due payment per the remittance advice, you will also receive a warrant (payment).

Providers billing electronically also have the option to receive their remittance advice electronically. Please contact the electronic billing unit at 360-902-6511 or 6512 for format specifications and activation.

Page one of the provider's remittance advice is the "Newsletter." Its free-form text relays information about the payment cycle, future warrants, billing instructions, rule changes, fee schedule changes, future workshops, etc.

The middle page(s) inform the provider or injured/ill worker which bills are being paid in the warrant, which bills denied and which bills are pending. At the very end of this section, it will list all explanation of benefit codes used in the remittance.

The last page of the remittance advice is the Notice that informs you of your right to request reconsideration or appeal any payment determination in the remittance advice.

PAYEE PROVIDER NUMBER	Provider's State Fund payee account number.
REMITTANCE ADVICE NUMBER	Sequence number in this warrant register.
WARRANT REGISTER NUMBER	Number assigned to this payment cycle.
DATE	Date of this payment cycle.
CLAIM NUMBER	Injured worker's L&I claim number.
NAME	Injured worker's last name and first initial.
PATIENT ACCOUNT/ PRESCRIPTION NUMBER	Account number or prescription number assigned by the provider or pharmacy to identify the injured worker, bill, or prescription.
ICN	Internal Control Number L&I assigned to permanently identify this bill.
SERVICE DATES FROM	The date of service or the beginning date of a service period.
SERVICE DATE TO	The date of service or the ending date of the period.

UNIT OF SERVICE	The number of days/visits/time units/miles.
PROCEDURE / REVENUE / NDC	The CPT/L&I procedure code/revenue code/NDC.
ALLOWED	The amount payable.
BILLED CHARGES	Amount the provider billed.
TAX OR NON COVERED CHARGES	The amount of sales tax payable or the amount of hospital charges not payable.
PAYABLE	The total amount L&I is paying.
EXPLANATION OF BENEFIT (EOB) CODES	The explanation of benefit reason code for the amount being paid or not paid. These codes can be applicable to the total bill or to specific line charges.
PAID BILL	The bill by type of bill being paid in this warrant in line-item detail.
DENIED BILLS	The bills and types of bill forms that are being denied in this remittance.
BILLS-IN-PROCESS	The bills that have been received and entered into MIPS, but have not cleared all adjudication edits in time for this payment cycle's cutoff date.
CREDIT BALANCE BILLS (CRE)	The bills that are being held in abeyance until a credit balance is satisfied. These bills should be treated as "Bills in Process". Do not post or rebill these bills as long as they appear in this section. **This is money owed to the department.**
BILLS RETURNED	Resubmit original returned bill with the information requested.
PAID BILLS - GROSS ADJUSTMENT	The bills and types of bills being paid in this warrant in summary detail only.
DENIED BILLS - GROSS ADJUSTMENT	The bills and types of bills being denied in this remittance in summary detail only.
BILLS PAID MTD	The total number of bills paid this month to date.

AMOUNT PAID MTD	The total dollar amount paid this month to date.
BILLS PAID YTD	The total number of bills paid this year to date.
AMOUNT PAID YTD	The total dollar amount paid this year to date.
BILLS DENIED/ RETURNED MTD	The total number of bills denied and/or returned this month to date.
BILLS DENIED/ RETURNED YTD	The total number of bills denied and/or return this year to date.
EOB EXPLANATIONS	The narrative explanation of the EOB codes appearing on this remittance advice.

After you have reviewed your remittance advice and if you should disagree with the amount paid, please submit a ***"Providers Request for Adjustment"*** form referencing the ORIGINAL ICN within 90 days. If you should disagree with the action taken, please submit a request for reconsideration.

BLMC8000-R001
AS OF 06/15/2001

DEPARTMENT OF LABOR AND INDUSTRIES
OLYMPIA, WASH 98504

007589

REMITTANCE ADVICE

PROVIDER'S NAME
PROVIDER'S STREET ADDRESS
CITY, STATE ZIP

PAYEE PROVIDER NUMBER **0000000** REMIT ADVICE # **XXXXXX** WARRANT REGISTER NUMBER **XXXXX** DATE **06/19/2001** PAGE X

PROVIDER'S NAME
PROVIDER'S STREET ADDRESS
CITY, STATE, ZIP

- NEWSLETTER UPDATE -

BLMC8000-R001
AS OF 06/15/2001

DEPARTMENT OF LABOR AND INDUSTRIES
OLYMPIA, WASH 98504

007589

REMITTANCE ADVICE

PROVIDER'S NAME
PROVIDER'S STREET ADDRESS
CITY, STATE ZIP

PAYEE PROVIDER NUMBER **0000000** REMIT ADVICE # **XXXXXX** WARRANT REGISTER NUMBER **60048** DATE **06/19/2001** PAGE **X**

CLAIM NUMBER	NAME	I	PATIENT ACCT/RX NUMBER	ICN	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	BILLED CHARGES	ALLOWED	TAX OR NON-COVD CHARGES	PAYABLE	EOB CODES
PAID BILLS - NURSING HOME BILL													
X000000	XXXXXXX	X	XXXXXXXXXX	0117125045000200	041101	041101	1	XXXXX	XXX.XX	XXX.XX	0.00	XXX.XX	
					041401	041401	1	XXXXX	XXX.XX	XXX.XX	0.00	XXX.XX	
					042401	042401	1	XXXXX	XXX.XX	XXX.XX	0.00	XXX.XX	
					043001	043001	1	XXXXX	XXX.XX	XXX.XX	0.00	XXX.XX	
					BILL TOTAL***				XXXX.XX	XXXX.XX	0.00	XXXX.XX	
**PAID BILLS TOTAL - NURSING HOME BILLS					**NUMBER OF BILLS-			1	XXXX.XX	XXXX.XX	0.00	XXXX.XX	
BILLS-IN-PROCESS - NURSING HOME BILL													
X000000	XXXXXXX	X	XXXXXXXXXX	0117125045000300	052201	052201	1	XXXXX	XXX.XX	0.00	0.00	0.00	
					052401	052401	1	XXXXX	XXX.XX	0.00	0.00	0.00	
					BILL TOTAL ***				XXX.XX	0.00	0.00	0.00	559
Y000000	XXXXXXX	X	XXXXXXXXXX	0116525013000100	041501	041501	1	XXXXX	XXX.XX	0.00	0.00	0.00	
					041501	050301	2	XXXXX	XXX.XX	0.00	0.00	0.00	
					041501	041501	1	XXXXX	XXX.XX	0.00	0.00	0.00	
					BILL TOTAL***				XXX.XX	0.00	0.00	0.00	
*** BILLS PENDING TOTAL - NURSING HOME BILLS					**NUMBER OF BILLS-			2	XXX.XX	0.00	0.00	0.00	

TOTAL WARRANT AMOUNT XXXX.XX

*** BILLS PAID MTD 1 *** AMOUNT PAID MTD XXXX.XX *** BILLS PAID YTD 1 *** AMOUNT PAID YTD XXXX.XX
*** BILLS DENIED/RETURNED MTD 0 *** BILLS DENIED/RETURNED YTD 0

********** THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION CODES UTILIZED ABOVE: **********

559 THIS BILL IS BEING ACTED UPON. DO NOT REBILL OR SUBMIT ADJUSTMENT UNTIL BILL IS DENIED OR PAID.

0	01171	25	045	000300
***Media**	**Julian Date**	**Film Roll Number**	**Batch Number**	**Bill Number**

*** ICN numbers that begin with a zero indicates that it is a paper bill.**
*** ICN numbers that begin with a 2, 3, or 5 indicates that it is an electronic bill.**

BLMC8000-R001
AS OF 06/15/2001

DEPARTMENT OF LABOR AND INDUSTRIES
OLYMPIA, WASH 98504

007589

REMITTANCE ADVICE

PROVIDER'S NAME
PROVIDER'S STREET ADDRESS
CITY, STATE ZIP

PAYEE PROVIDER NUMBER **0000000** REMIT ADVICE # **XXXXXX** WARRANT REGISTER NUMBER **60048** DATE **06/19/2001** PAGE **X**

CLAIM NUMBER	NAME	I	PATIENT ACCT/RX NUMBER	ICN	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	BILLED CHARGES	ALLOWED	TAX OR NON-COVD CHARGES	PAYABLE	EOB CODES
PAID BILLS -		NURSING HOME BILL											
Y000000	XXXXXXX	X	XXXXXXXXXX	00117025064001000	050101	050101	1	XXXXX	XX.XX	XX.XX	0.00	XX.XX	
					050201	050201	1	XXXXX	XX.XX	XX.XX	0.00	XX.XX	
					050201	050201	1	XXXXX	XX.XX	XX.XX	0.00	XX.XX	
					050301	050301	1	XXXXX	XX.XX	XX.XX	0.00	XX.XX	
					051901	052501	36	XXXXX	XXX.XX	XXX.XX	0.00	XXX.XX	
					052601	060101	36	XXXXX	XXX.XX	XXX.XX	0.00	XXX.XX	
					BILL TOTAL***				XXX.XX	XXX.XX	0.00	XXXX.XX	
**PAID BILLS TOTAL - NURSING HOME BILLS					**NUMBER OF BILLS-			1	XXX.XX	XXX.XX	0.00	XXXX.XX	
ADJUSTMENT - BILLS -		GROSS ADJUSTMENT											
X000000	XXXXXXX	X	XXXXXXXXXX	40117000952000002	050101	060101	0		XX.XX-	XX.XX-	0.00	XX.XX-	T03
X000000	XXXXXXX	X	XXXXXXXXXX	40117000953000002	050101	060101	0		X.XX-	X.XX-	0.00	X.XX-	T04
X000000	XXXXXXX	X	XXXXXXXXXX	40117000954000002	050101	060101	0		XX.XX-	XX.XX-	0.00	XX.XX-	T05
X000000	XXXXXXX	X	XXXXXXXXXX	40117000957000002	050101	060101	0		XX.XX-	XX.XX-	0.00	XX.XX-	T08
X000000	XXXXXXX	X	XXXXXXXXXX	40117000958000002	050101	060101	0		X.XX-	X.XX-	0.00	X.XX-	T09
**ADJUSTMENT TOTALS - GROSS ADJUSTMENT					**NUMBER OF BILLS-			5	XX.XX-	XX.XX-	0.00	XX.XX-	
									TOTAL WARRANT AMOUNT		XXX.XX		

*** FICA SS TAX XX.XX *** FICA MCARE TAX X.XX *** TOTAL WAGES XXX.XX
*** FICA SS YTD XX.XX *** FICA MCARE TAX X.XX *** TOTAL WAGES YTD XXX.XX
*** BILLS PAID MTD 22 *** AMOUNT PAID MTD XXX.XX *** BILLS PAID YTD 22 *** AMOUNT PAID YTD XXX.XX
*** BILLS DENIED/RETURNED MTD 0 *** BILLS DENIED/RETURNED YTD 0

********** THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION CODES UTILIZED ABOVE: **********

T03 EMPLOYER FICA SOCIAL SECURITY
T04 EMPLOYER FICA MEDICARE
T05 EMPLOYER FEDERAL UNEMPLOYMENT
T08 EMPLOYEE FICA SOCIAL SECURITY
T09 EMPLOYEE FICA MEDICARE

BLMC8000-R001
AS OF 06/15/2001

DEPARTMENT OF LABOR AND INDUSTRIES
OLYMPIA, WASH 98504

007589

REMITTANCE ADVICE

PROVIDER'S NAME
PROVIDER'S STREET ADDRESS
CITY, STATE ZIP

PAYEE PROVIDER NUMBER **0000000** REMIT ADVICE # **XXXXXX** WARRANT REGISTER NUMBER **XXXXX** DATE **06/19/2001** PAGE **X**

******* REMITTANCE ADVICE LEGAL NOTICE *******

INITIAL PAYMENTS OR ADJUSTMENTS RESULTING IN INCREASED PAYMENTS MADE ON THIS REMITTANCE ADVICE WILL BECOME FINAL SIXTY (60) DAYS AFTER RECEIPT UNLESS YOU FILE A REQUEST FOR RECONSIDERATION OR A PROVIDER'S REQUEST FOR ADJUSTMENT FORM WITH THE DEPARTMENT WITHIN THAT TIME.

ADJUSTMENTS MADE TO PREVIOUS PAYMENTS ON THIS REMITTANCE ADVICE RESULTING IN DECREASED PAYMENTS WILL BECOME FINAL TWENTY (20) DAYS AFTER RECEIPT UNLESS: 1) YOU FILE A WRITTEN REQUEST FOR RECONSIDERATION OR 2) A PROVIDER'S REQUEST FOR ADJUSTMENT FORM WITH THE DEPARTMENT OR 3) AN APPEAL WITH THE BOARD OF INDUSTRIAL INSURANCE APPEALS WITHIN THAT TIME.

ADJUSTMENT AND/OR RECONSIDERATION REQUESTS MUST BE SENT TO THE DEPARTMENT OF LABOR AND INDUSTRIES, PO BOX 44267, OLYMPIA, WA 98504-4267

APPEALS MUST BE SENT TO THE BOARD OF INDUSTRIAL INSURANCE APPEALS, 2430 CHANDLER CT SW, OLYMPIA WA 98504-2401.

REBILLS

REBILLS should be submitted when:

Your TOTAL BILL has been denied.
Your bill was sent in over 60 days ago and is not yet showing up on your Remittance Advice
You are **required** to REBILL: (WAC 296-20-125)

- For TOTAL BILLS denied because the claim was closed and the claim has now been reopened
- For TOTAL BILLS denied because the claim was first rejected and the claim has now been allowed.
- For TOTAL BILLS denied because a diagnosis was at first not allowed and the diagnosis has now been allowed

Rebills must be received at the department **within one year of the date the final order was issued** which reopened or allowed the claim or diagnosis.

A rebill should be identical to the original bill: same charges, codes and dates of service.
Rebills should be submitted on new ORIGINAL bill forms. We cannot process photocopies or facsimiles.

ADJUSTMENTS

A "Providers Request for Adjustment" form (F245-183-000) should be submitted to correct an incorrect field on a bill that has **already processed and partially paid**.

Enter the workers name (field 1), their claim number as it appears on your REMITTANCE ADVICE (field 2), the correct claim number if applicable (field 3), the providers mane and address (field 4), the ICN (internal control number) of the bill (field 5) as it appears on your REMITTANCE ADVICE (see example headings below for location of the ICN as it appears on your REMITTANCE ADVICE), the performing providers L&I provider number (field 6) and L&I payee number (field 7), if applicable.

Claim #	Name	I	Patient Acct#	ICN	Service Dates From	To	Unit	Procedure	Billed Charge
P000000	XXXXXXX	X	XXXXXXXXXX	**00103625045000200**	121300	121700	1	XXXXX	XX.XX

In the body of the form (field 8) complete only those line item fields that have been paid or denied incorrectly due to incorrect information. Enter only the corrected information in the line item fields corresponding to the line item fields on your bill as it appears on your REMITTANCE ADVICE.

EXAMPLE:
You billed one unit of service on line one but four units were actually completed and should be payable. You've only been paid for one unit. Everything else on the bill is correct. In field 8, on line one of the adjustment form, enter '4' in the 'unit' field. After the adjustment processes you will receive payment for the three units previously unpaid.

Please attach to the adjustment form a copy of your ORIGINAL BILL and a copy of the page of your REMITTANCE ADVICE where your paid bill appears.

Request for Reconsideration on **adjustments initiated by the department:**

Per legal notice on your REMITTANCE ADVICE, a request for reconsideration of a decreased adjusted payment must be made in writing within 20 days of receipt of payment.

The basis for the request for reconsideration must be other than an objection to the payment amount established by the departments fee schedule.

All supporting documentation relevant to the reconsideration request should be submitted with the request.

Note:
DO NOT SUBMIT an adjustment or a rebill for a bill that is reported "in process" on your Remittance Advice. If the bill remains in the "in process" status for **over 60 days**, call our Provider Hotline at 1-800-848-0811. For bills "in process" **under 60 days** you may access the Claim Information Line by calling 1-800-831-5227. Once you access the 'in process' bill information, you may choose the 'zero' option to be connected to the bill payment section.

Adjustments will appear as the last item on the Remittance Advice as follows:

(See sample RA on next page)

Your original bill will be reprinted, appearing as a credit for the amount previously paid, (e.g., $100.00 - CRE).

Your adjustment will usually appear immediately following the credit of your bill.

If an additional payment is allowed, the total amount allowed for the bill will be reported (e.g., $125.00). The "adjusted payment" will be paid in the warrant (e.g., $25.00).

If no additional fee is allowable, the amount of the adjustment will be equal to the credit of the previous payment (e.g., $100.00).

If the original payment is being recouped, the total amount allowed for the bill will be reported (e.g., $0.00). The "adjusted payment" will recoup the original amount of the bill.

NO STAPLES IN
BAR CODE AREA

[redacted]

Department of Labor and Industries
PO Box 44267
Olympia WA 98504-4267

PROVIDER'S REQUEST FOR ADJUSTMENT

CHECK→ ONE

- ☐ TOTAL OVERPAYMENT
- ☐ PARTIAL OVERPAYMENT
- ☐ UNDERPAYMENT

DO NOT WRITE IN SPACE >

Please type or print in dark ink

ENTER DATA FROM ORIGINAL REMMITTANCE ADVICE	**INSTRUCTIONS ARE ENCLOSED**	
1) WORKERS NAME (Last, First, Middle)	2) CLAIM NUMBER ON REMIT ADVICE	3) CORRECT CLAIM NUMBER
4) PROVIDER NAME AND ADDRESS	5) ICN NUMBER ON REMITTANCE ADVICE	
	6) PROVIDER NUMBER	
	7) PAYEE NUMBER	

COMPLETE ONLY THOSE LINE ITEMS PAID/DENIED IN ERROR - ENTER ONLY CORRECTED INFORMATION

8) Line Item #	a) From/to Date of Service or Covered Dates	b) POS	c) TOS	d) Procedure Code/ Revenue Code/NDC	e) CODE MOD	f) ICD-9-CM Diagnosis/ Side of Body	g) Tooth Number	h) Charge	i) Days/ Units/ Quantity	j) Days Supply	k) Description
01											
02											
03											
04											
05											
06											
07											
08											
09											
10											
11											
12											
13											
14											

9. OTHER REMARKS/JUSTIFICATIONS/SPECIAL CIRCUMSTANCES - ATTACH REQUIRED REPORTS - EXPLAIN FULLY

DATE	SIGNATURE OF PERSON COMPLETING FORM	PHONE NUMBER
		( )

ADJUSTMENT REQUEST FORM

THE ADJUSTMENT REQUEST FORM MAY BE USED IN THE FOLLOWING INSTANCES:

TOTAL OVERPAYMENT ---- Entire bill was paid in error. You may either submit an Adjustment Request Form and we will process a credit to recover our payment; OR you may issue a refund check directly to the Department. If a refund is submitted, you must attach a copy of the remittance advice indicating the ICN overpaid. Submit refunds to:

Cashiers Office
Department of Labor and Industries
PO Box 44835
Olympia WA 98504-4835

PARTIAL OVERPAYMENT --- A portion of the bill was overpaid. Complete Adjustment Request Form with correct information, including date of service, for the procedures/items paid incorrectly.

UNDERPAYMENT ---------- If a bill has been underpaid in error, the Adjustment Request Form must be completed with all pertinent information including date of service. Corrections or justification and/or reports must be included.

This form may **NOT** be used for:
Bills returned to you by the Department **OR** totally denied bill. New bill must be submitted.

INSTRUCTIONS FOR COMPLETING ADJUSTMENT REQUEST

Submit only one form for each ICN (Internal Control Number).
Attach a copy of remittance advice and original bill.

1. **WORKER'S NAME:** Clearly print injured worker's full name.
2. **CLAIM NUMBER ON REMITTANCE ADVICE:** Enter the 7-digit number found in the Claim Number column on the remittance advice.
3. **CORRECT CLAIM NUMBER:** Claim number these services should be paid under.
4. **PROVIDER NAME AND ADDRESS:** Enter the name and address of the provider providing the service. Include telephone number.
5. **ICN NUMBER:** Enter the 17-digit number found in the ICN column to identify the bill submitted.
6. **PROVIDER NUMBER:** Enter the Labor and Industries provider account number for the provider of service as it appears on the remittance advice.
7. **PAYEE NUMBER:** Enter the Labor and Industries payee provider account number if payee was **different** than the provider of service.
8. **SERVICE ITEMIZATION:** Complete only for those line items to be corrected. Enter corrected information on line item number corresponding to line item number on original bill.
    a. **From/to Date of Service or Covered Dates:** Date of Service, from and to date if date span previously billed. Admit and discharge date for hospital bill.
    b. **Place of Service:** (POS) Two digit code identifying the place of service was performed.
    c. **Type of Service:** (TOS) One digit code identifying the general type of service performed.
    d. **Procedure Code/Revenue Code/NDC:** Identify correct procedure, hospital service or national drug code.
    e. **Code Mod:** Modifier used to identify special circumstances for a service or procedure.
    f. **ICD-9-CM Diagnosis/Side of Body:** ICD-9-CM diagnosis code for condition treated. Designate left or right side of body where applicable.
    g. **Tooth Number:** For dental services only. Enter the two digit identification number of the specific tooth number treated (e.g., 08).
    h. **Charge:** Total of charges for services provided this line.
    i. **Days/Units/Quantity:** Total days stay for hospital accommodation codes, unit of service for procedure (time units, hours, miles, etc.), number of items (tablets, milliliters, etc.).
    j. **Days Supply:** Total number of days a prescription is intended to cover.
    k. **Description:** Describe procedure or service.
9. **OTHER REMARKS/JUSTIFICATION/SPECIAL CIRCUMSTANCES:** Enter sufficient justification for adjustment. Indicate the service line and date of service. Attach required reports.

LABOR & INDUSTRIES RESOURCE LIST

Billing Information

State Fund Provider Accounts **(360) 902-5140**
Provider Accounts staff can assist you in obtaining an L&I provider account number and answer questions in regards to your L&I provider account number.

Electronic Billing **(360) 902-6511 or 902-6512**
To obtain information on electronic transfer, tape-to-tape, or direct entry billing.

Claims Unit Customer Service Representatives

Unit	Phone Number	Unit	Phone Number
A	(360) 902 - 4498	R	(360) 902 - 4506
B	(360) 902 - 4491	T (UW)	(206) 281 - 5509
C	(360) 902 - 4490	U	(360) 902 - 4514
D	(360) 902 - 4315	W	(360) 902 - 4496
E	(360) 902 – 4331	X	(360) 902 - 4507
F	(360) 902 - 4502	Y	(360) 902 – 4453
G	(360) 902 - 4518	Z	(360) 902 – 6572
H	(360) 902 - 4493	3	(360) 902 – 5129
J	(360) 902 - 6455	4	(425) 290 – 1335
K	(360) 902 - 4361	5	(509) 454 - 3714 or 3726
L	(360) 902 - 4457	7	(360) 902 – 4745
M	(360) 902 - 4494	8	(360) 902 – 6643
N	(360) 902 – 4497	9	(360) 902 – 5665
O	(360) 902 – 9139	Tacoma	(253) 596 – 3947
P	(360) 902 – 4495		

Claims Unit Occupational Nurse Consultants

Unit	Phone Number	Unit	Phone Number
A & B	(360) 902 – 4293	C	(360) 902 – 4411
P & R	(360) 902 – 4520	W & Y	(360) 902 – 5820
D, X, & 6	(360) 902 – 4322	2	(509) 324 – 2559
E & F	(360) 902 – 4335	3	(360) 902 – 6804
G & J	(360) 902 – 6690	4	(425) 290 – 1331
H & Z	(360) 902 – 6425	5	(509) 454 – 3729
K, L, & O	(360) 902 – 6743	8 & 9	(360) 902 – 9105
M & N	(360) 902 – 6682	T (UW)	(206) 281 – 5522
7 & U	(360) 902 - 4382	Tacoma	(253) 596 – 3904

Office of the Medical Director **(360) 902-5024 or 902-5026**

Inpatient/Outpatient Utilization Review **1-800-541-2894**

Provider Hotline **1-800-848-0811**
Bill payment/denial questions, interpretation of Provider Bulletins, WAC's & RCW's, authorization of non-targeted radiological and diagnostic testing services, consultations, orthotics, prosthetics, durable medical equipment, hearing aids/supplies and massage therapy.

IVR (Interactive Voice Response) **1-800-831-5227**
For claim status, allow/denied diagnoses, procedures & drug classes, pending bills, Claim Manager name and phone number. ***Have your L&I provider account number and claim number ready.***

IME Project Manager **(360) 902-6818**

Regional Offices - General Information

Aberdeen	(360) 533-8200	Okanogan	(509) 826-7345
Bellevue	(425) 990-1400	Port Angeles	(360) 417-2700
Bellingham	(360) 647-7300	Pullman	(509) 334-5296
Bremerton	(360) 415-4000	Seattle	(206) 281-5400
Colville	(509) 684-7417	Spokane	(509) 324-2600
East Wenatchee	(509) 886-6500	Tacoma	(253) 596-3800
Everett	(425) 290-1300	Tukwila	(206) 248-8240
Kennewick	(509) 735-0100	Tumwater	(206) 902-5799
Longview	(360) 575-6900	Vancouver	(360) 896-2300
Moses Lake	(509) 764-6900	Walla Walla	(509) 527-4437
Mount Vernon	(360) 416-3000	Yakima	(509) 454-3700

Safety & Health Assessment & Research for Prevention **(360) 902-5667**

Self-Insurance Information **(360) 902-6901**
For questions relating to the treatment of an injured worker employed by a self-insured business.

Other phone numbers:

Worker Hotline **1-800-LISTENS or 1-800-547-8367**